

**AUTHORIZATION TO DISCLOSE
HEALTH INFORMATION**

Patient name: Brett Spencer Lovelace DOB: 08/21/1999 SSN: 430-97-8891

1. I authorize the use or disclosure of the above named individual's health information as described below:
2. The following individual or organization is authorized to make the disclosure:

Pediatric Anesthesiologists, P.A.
50 North Dunlap Street
2nd Floor, Research Tower
Memphis, TN 38103

Pediatric Anesthesiologists, P.A.
Attn: Donald E. Bourland
5400 Poplar Avenue, Suite 100
Memphis, TN, 38119

Babu Rao Paidpalli
c/o Pediatric Anesthesiologists, P.A.
50 North Dunlap Street
2nd Floor, Research Tower
Memphis, TN 38103

Babu Rao Paidipalli
c/o Le Bonheur East Surgery Center
786 Estate Place
Memphis, TN 38120

Mark P. Clemons, M.D.
6616 Kirby Center Cove
Memphis, TN, 38115

Mark P. Clemons, M.D.
228 West Tyler, Suite 100
West Memphis, AR 72301

3. The type and amount of information to be used or disclosed is as follows: (include dates where appropriate)

_____ problem list
_____ medication list
_____ list of allergies
_____ immunization record
_____ most recent history and physical
_____ most recent discharge summary
_____ laboratory results
_____ x-ray and imaging reports

_____ consultation reports
_____ (all treating physicians/nurses and caretakers)
_____ entire record
_____ other: billing records

4. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

5. This information may be disclosed to and used by the following individual or organization:

Pediatric Anesthesiologists, P.A.
50 North Dunlap Street
2nd Floor, Research Tower
Memphis, TN 38103

Pediatric Anesthesiologists, P.A.
Attn: Donald E. Bourland
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6. I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition: December 31, 2014. If I fail to specify an expiration date, event or condition, this authorization will expire in six months.

7. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact (insert HIM director, privacy officer, or other office or individual's name or contact information.)
8. Nothing in this Authorization shall be construed as permitting the ex parte communication between counsel for the Defendants and the healthcare providers of Brett Spencer Lovelace (Plaintiffs' Decedent, and Son) without the express permission and/or the participation of Helen Lovelace, Daniel Lovelace, or their attorneys.
9. I hereby agree that a copy of this authorization form or facsimile shall have the same force and effect as the original thereof.

Helen Lovelace
Helen Lovelace
Mother of Brett Spencer Lovelace

1/25/13
Date

Daniel Lovelace
Daniel Lovelace
Father of Brett Spencer Lovelace

[Signature]
Signature of Witness

STATE OF TENNESSEE

COUNTY OF SHELBY

On this 25th day of January 2013, before me personally appeared Helen Lovelace and Daniel Lovelace known to me to be the persons described herein and who executed the foregoing Authorization to Release Medical Information and that they executed the same as their free act and deed.

[Signature]
NOTARY PUBLIC



My commission expires: 9-21-2016

SENDER: COMPLETE THIS SECTION		COMPLETE THIS SECTION ON DELIVERY	
<ul style="list-style-type: none"> ■ Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired. ■ Print your name and address on the reverse so that we can return the card to you. ■ Attach this card to the back of the mailpiece, or on the front if space permits. 		A. Signature X <i>Michelle Blocker</i> <input type="checkbox"/> Agent <input type="checkbox"/> Addressee	
1. Article Addressed to: <i>Pediatric Anesthesiologists, P.A.</i> <i>50 N. Dunlap Street</i> <i>2nd Floor, Research Tower</i> <i>Memphis, TN 38103</i>		B. Received by (Printed Name) <i>Michelle Blocker</i>	C. Date of Delivery <i>2/14/13</i>
		D. Is delivery address different from item 1? <input type="checkbox"/> Yes If YES, enter delivery address below: <input type="checkbox"/> No	
		3. Service Type <input checked="" type="checkbox"/> Certified Mail <input type="checkbox"/> Express Mail <input type="checkbox"/> Registered <input checked="" type="checkbox"/> Return Receipt for Merchandise <input type="checkbox"/> Insured Mail <input type="checkbox"/> C.O.D.	
		4. Restricted Delivery? (Extra Fee) <input type="checkbox"/> Yes	
2. Article Number (Transfer from service label)		7007 0710 0004 1355 4567	
PS Form 3811, February 2004		Domestic Return Receipt	
		102595-02-M-1540	